

Personal Care Services (PCS)

Annual Medicaid Conference
October 2012

DHCFP with HPES

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Covered topics

- ✓ PCS Program
- ✓ Authorization Requests
- ✓ Requesting a Functional Assessment
- ✓ At Risk Recipients
- ✓ Billing for Services



PCS Purpose

- To assist, support and maintain recipients living independently in their homes and in settings outside their homes, including employment sites
- Assistance with Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL)
- To provide services where appropriate, medically necessary and within service limitations.



Agency types

- PCS Provider Agency (provider type 30)
Medicaid Services Manual Chapter 3500
- Intermediary Service Organization (provider type 83)
Medicaid Services Manual Chapter 2600



Program eligibility criteria

- The recipient has ongoing Nevada Medicaid or Nevada Check Up eligibility for services.
- The recipient is NOT in a facility of any type or group home.
- There is no Legally Responsible Individual (LRI) or other willing caregiver able and capable of assisting the recipient.
- The recipient must be cooperative in establishing the service plan and follow the approved service plan.
- The recipient must be capable of making choices about ADLs (or have a Personal Care Representative (PCR)).
- Service must be medically necessary as defined by the Division of Health Care Financing and Policy (DHCFP).



Personal Care Representative (PCR)



- An individual who is directly involved in the day-to-day care of a recipient and is available to direct care in the home
- This individual acts on behalf of the recipient when the recipient is unable to direct his/her own personal care services
- A PCR must be a responsible adult

Legally Responsible Individual (LRI)

Those individuals who are legally responsible to provide medical support to others, including:

- Spouses of recipients
- Parents of minor recipients including:
 - Stepparents
 - Foster parents
- Legal guardians



Legally Responsible Individual, continued

- If an LRI is able and capable, PCS cannot be authorized. A PCS is not intended to replace natural support systems.
- An LRI cannot be paid to provide PCS services to the individual for which he or she is legally responsible.



Capable vs. Incapable Caregivers

Capable Caregiver

- A capable caregiver is a responsible adult who is physically and cognitively capable of carrying out necessary maintenance, health/medical care, education, supervision, support services, and/or the provision of needed ADLs and IADLs.

Incapable Caregiver

- A caregiver who is unable to safely manage required care due to:
 - Cognitive limitations (unable to learn care tasks, memory deficits) or is infirm
 - Documented physical limitations (unable to render care such as inability to lift recipient)
 - Significant health or emotional issues
 - Caregiver incapability must be documented by the caregiver's treating physician, and must directly prevent or interfere with provision of care



Able vs. Unable Caregivers

Able Caregiver

- An able caregiver is an LRI who has the option to be in the home during the time necessary for maintenance, health/medical care, education, supervision, support services and/or the provision of needed ADLs and IADLs

Unable Caregiver

- A caregiver who is unable to be present in the home for the provision of ADLs and IADLs due to hours of employment or school attendance commitments
 - Caregiver unavailability must be verified with proper documentation from the LRI's place of employment or school



Services to Assist with ADLs

Personal care services to assist with the following ADLs may be authorized when medically necessary and within service limitations:

- Bathing/dressing/grooming
- Toileting
- Transfers from one stationary position to another
- Mobility/ambulation
- Eating



IADL Covered Services

These services may be covered when a significant need for ADL is identified and IADLs are found to be medically necessary.

- Housekeeping
- Laundry
- Essential Shopping
- Meal Preparation

Note: Services may be hands on or cueing may be provided.

IADLs may only be provided in conjunction with ADLs and only when no LRI is able and capable.



Escort services

The service plan allows:

- A Personal Care Attendant (PCA) who accompanies a recipient into the community to provide authorized personal care services enroute to or while obtaining Nevada Medicaid or Nevada Check Up covered services.
- Are NOT part of the routine service plan
- A single service authorization request must be submitted to HP Enterprise Services (HPES) and will be reviewed for medical necessity



Self-Directed Skilled Services

- The primary physician determines the recipient's condition is stable and predictable.
- The primary physician determines that the procedures involved in providing services are simple, can be performed by a PCA, and do not pose a substantial risk to the recipient.
- A licensed health care professional determines that the PCA has the knowledge, skill and ability to competently perform the services.



Self-Directed Skilled Services, continued

- The PCA agrees to refer the recipient to the primary physician when the recipient's condition changes, the recipient develops a new medical condition, the progress of the recipient is different than expected, and/or an emergency situation or other type of situation develops.
- Services must be in the presence of the LRI if the recipient is unable to direct their own care, i.e., minor child, cognitively impaired adult, etc.

Note: LRIs must have already provided proof of disability; otherwise, they would be expected to perform the skilled service themselves.



Self-Directed Skilled Services, continued

Covered Services

- Approved for recipients who are chronically ill or disabled who require skilled care to remain in the home.
- Services are medically necessary to maintain or improve the recipient's health status.
- Service(s) performed must be one that a person without a disability usually and customarily would perform for self without the assistance of a health care provider.
- Services must be sufficient in amount, duration and scope to reasonably achieve its purpose.

Note: Skilled services are not allowed by PCS provider agency PCAs. The recipient must select the Self-Directed Model through an Intermediary Service Organization (ISO).



Types of Self-Directed Skilled Services

Skilled services, include, but are not limited to:

- Medication set-up and administration
- Wound care
- Vital sign monitoring
- Skin and nail care
- Catheter care
- Glucose testing
- Insulin administration
- Specialized feeding technique,
- Oxygen application and monitoring
- Nebulizer treatments



Non-Covered PCS Services



- Chore Services – including interior and exterior maintenance and yard work
- Services when the recipient resides in a group home, nursing facility, ICF/MR, or an institution for the mentally ill
- Any task that DHCFP determines can be reasonably done by the recipient
- Services normally provided by an LRI or able and capable caregiver
- Any task not authorized on the approved service plan

Non-Covered PCS Services, continued

- Services provided to someone other than the recipient
- Services to maintain an entire household, such as cleaning areas of the house not solely used by the recipient
- Companion care, baby-sitting, supervision or social visitation
- Care of pets (except service animals)
- Respite care
- Social visits
- Escort services for social, recreational or leisure activities



Adverse Action

An adverse action is a denial, termination, reduction or suspension of a recipient's request for services or eligibility determination.

The DHCFP or their designee will notify the recipient with a Notice of Decision (NOD) if an adverse action is taken when:

- The recipient does not meet the Personal Care Service (PCS) eligibility criteria
- The recipient's parent and/or legal guardian is responsible for the maintenance, health care, education and support of their child
- Services requested exceed service limits
- Services requested are non-covered benefits



Adverse Action, continued

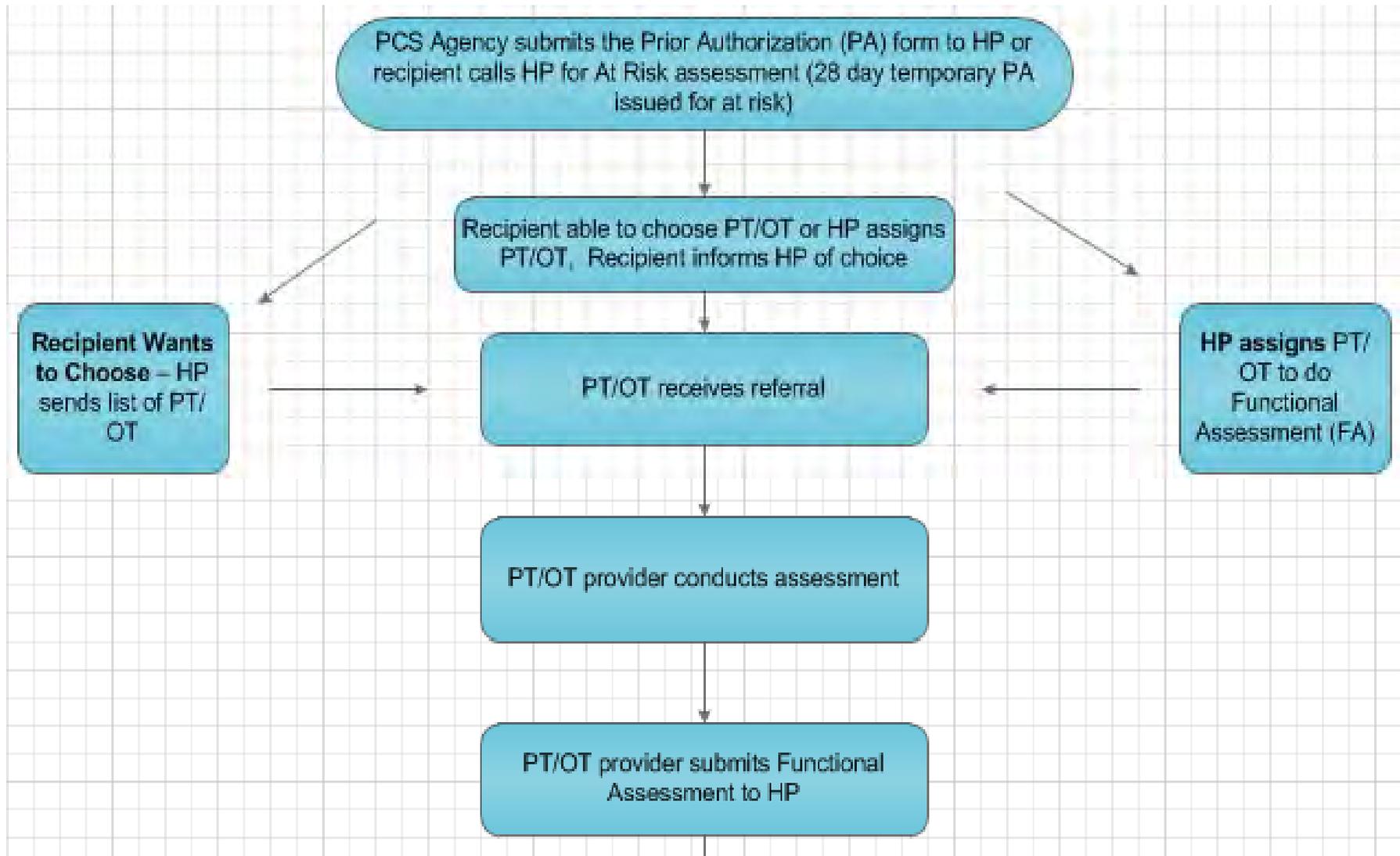
- The recipient, the PCR, or their LRI refuses services or is non-cooperative in the establishment of services
- The recipient, the PCR, or their LRI refuses services in accordance with the approved service plan
- All or some services are no longer necessary as demonstrated by the functional assessment (FA)
- The recipient's needs can be met by the LRI
- Another agency or program provides or could provide the service



Requesting Personal Care Services



Personal Care Services Process Flow



Process Flow, continued

HP performs Clinical Review of Functional Assessment, policy and completes the Service Plan

Copy of the Service Plan mailed to recipient, fax'd or emailed to appropriate District Office, and fax'd to PCS agency on the date processed by HP

- Key Notes:
- Re-certifications (change in status) and Initials (first time) are to be completed (PA and Service Plan done) within 21 business days from date of request.
- Annual reassessments are due the day after the last day of the month the PA expires.. These are done/due every 365 days, unless there is a change in condition. Referral made to District Office or Case Manager as needed.
- If needed, the PA is extended if the Service Plan is not returned to HP timely to prevent gap in service.



Types of Assessments

- Initial
- Reassessment
 - Currently completed 30 days prior to the end of the current authorized service period
 - May be requested if the recipient has had a significant change in condition or circumstance, which may indicate the need for additional time



Requesting Personal Care Services

- A request for initial (first time) services must be submitted by one of the following individuals:
 - The recipient
 - The recipient's PCR or LRI
 - Waiver case manager, FOCIS staff, discharge planners, etc
 - Providers are not allowed to make initial requests
- When requesting a functional assessment for PCS, an FA-24 form must be completed first. The form is found on the website: at www.medicaid.nv.gov select "Forms" from the "Providers" tab, then scroll to form FA-24.
- A functional assessment (FA) must be submitted to HPES before the service can be authorized



Requesting Personal Care Services, continued

- Functional assessments must be performed by an approved Nevada Medicaid enrolled physical **or** occupational therapist
- HPES performs clinical review of Functional Assessment, applies Medicaid policy, completes the Service Plan and authorizes services
- A copy of the Service Plan is mailed to the recipient, faxed or emailed to the appropriate District Office, and faxed to the PCS agency on the date processed by HPES



At Risk Recipients



Who Is An At Risk Recipient?

- A recipient for whom the absence of PCS would likely result in medical deterioration, medical complications or might jeopardize the recipient's personal safety if PCS is not received within 24 hours
- A recipient who is in danger of being institutionalized (hospitalization, ER, nursing facility)
- A recipient who is in danger of not being able to return to a community setting
- A recipient who temporarily or permanently loses their primary caregiver or LRI



At Risk Recipient Process

- Upon an initial request for PCS and prior to the completion of an FA, HPES completes a telephonic risk assessment to identify any at risk recipient
- HPES provides a 28-day temporary service authorization for identified at risk recipient
- The recipient is given the opportunity to select a physical or occupational therapist to complete their FA and a list of available agencies to provide PCS
- The selected agency is notified when a recipient is at risk and agrees to initiate needed services within 24 hours of an accepted referral
- The selected physical or occupational therapist schedules and completes the FA during the 28-day period
- HPES completes the service plan and authorizes on-going services



PCS Authorization Requests



Significant Change Requests

- Requests for reassessment due to significant change in the recipient's condition or circumstance must be submitted to HPES as soon as the significant change is known. A request must be accompanied by documentation from the recipient's physician or health care provider. A waiver case manager can also provide the required documentation when appropriate (not in policy but an acceptable practice).
- Significant change in circumstance may include absence, illness, or death of the primary caregiver or LRI.
- Significant change in condition or circumstance expects imminent hospitalization or other institutional placement if PCS are not reassessed to meet the recipient's change in service needs.



Modifications to the Service Plan and Authorization

- The recipient has an unexpected change in condition or circumstance that requires short-term (less than four weeks) modification of the current service plan and authorization. A new FA is not required.
- Examples for increased hours: acute medical episode, post-hospitalization period.
- Examples for decreased hours: improvement in a recipient's functional ability, additional availability by the LRI.



Single-Service Authorization Request

- A request for a single-service authorization when the recipient requires an extra visit for an unanticipated need(s), such as bowel or bladder incontinence is allowed
- Medical necessity of the services requested must be documented
- The requesting provider must provide the service(s) for the current authorization period
- A new FA is not required in these single-service situations
- The provider must identify on the request the date, the amount of time and the specific task completed for a one-time request



PCS Reassessment Authorization Requests

- Per policy, requests for ongoing PCS must be submitted to the QIO-like vendor at least 30 calendar days prior to the expiration date of the prior authorization.
- The DHCFP sent letters to providers on July 3, 2012, asking them to voluntarily make reassessment requests 60 calendar days prior to the expiration date. This will be changed in policy at a later date.



Contact Information
Glossary
Q&A



Contact information

Customer Service	
Phone	1-877-638-3472, option 2, then 3
Fax	1-775-335-8594
Email	NVMMISProviderServices@hp.com
PCS	
Phone	1-800-525-2395, option 2, then 4
Fax (Dental) Effective 10/201/12	1-855-709-6848
Fax (PCS and ADHC) Effective 10/1/2012	1-855-709-6846
All Other Authorizations	
Phone	1-800-525-2395
Fax	1-866-480-9903



Medicaid District Office Contacts

Carson City	1-775-684-3651
Elko	1-775-753-1191
Las Vegas	1-702-668-4200
Reno	1-775-687-1900



Waiver Contacts

DHCFP District Offices	
Carson City	1-775-684-3651
Elko	1-775-753-1191
Las Vegas	1-702-668-4200
Reno	1-775-687-1900
ADSD District Offices	
Carson City	1-775-687-4210
Elko	1-775-738-1966
Las Vegas	1-702-486-3545
Reno	1-775-688-2964
MHDS Regional Centers	
Desert Regional Center (Las Vegas)	1-702-486-1200
Rural Regional Center (Carson City)	1-775-687-5162
Sierra Regional Center (Reno)	1-775-688-1930



Questions and answers



Billing for PCS



Billing for PCS Services

- Refer to the PT30 Billing Guidelines located at www.medicaid.nv.gov. Select “Billing Information” from the “Providers” tab.
- The instructions are specific to PCS providers and must be used in conjunction with the CMS-1500 Claim Form instructions provided on the “Billing Information” webpage.
- If a recipient is eligible for Medicaid and Medicare, at this time Medicare does not provide coverage for HCPCS codes T1019 and A0160.
 - If a recipient is eligible for both Medicare and Medicaid, you may bill Medicaid first.
 - Include the word Medicare in Field 9d on your claim form.



Billing for PCS Services, continued

- Bill only for the dates when services were actually provided. If a service was provided on one day only, enter the same date in the From and To Date(s) of Service fields.
- If services were provided on Monday and also on Wednesday of the same week, but not on Tuesday, bill Monday and Wednesday individually on separate claim lines.
- Do not bill as one claim Monday through Wednesday or Sunday through Saturday, regardless if the authorization period is the full week. If the claim is billed improperly, the claim will be denied.



Billing a claim on a CMS-1500 paper form, continued

Fields 14-19 are conditional and not required.

14. DATE OF CURRENT: MM DD YY		ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE			17a.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
			17b. NPI				
19. RESERVED FOR LOCAL USE				20. OUTSIDE LAB?		\$ CHARGES	
				<input type="checkbox"/> YES <input type="checkbox"/> NO			

Field 20 is not a required field



Billing monthly when services are provided daily

Bill HCPCS code T1019. This code is a 15 min. per unit code.

2 units = 30 minutes, 4 units = 1 hr. of service, 8 units = 2 hr. of service

Bill A0160 for mileage: 1 mile = 1 unit (bill only if approved)

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)											22. MEDICAID RESUBMISSION CODE		ORIGINAL REF. NO.							
1. _____			3. _____																	
2. _____			4. _____																	
24. A. DATE(S) OF SERVICE											B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY	MM	DD	YY	CPT/HCPCS	MODIFIER										
1	03	01	12	03	07	12	12		T1019				U & C					N5	10-digit API	
2	03	08	12	03	14	12	12		T1019				U & C					N5	10-digit API	
3	03	15	12	03	21	12	12		T1019				U & C					N5	10-digit API	
4	03	22	12	03	28	12	12		T1019				U & C					N5	10-digit API	
5	03	29	12	03	31	12	12		T1019				U & C					N5	10-digit API	
6																				

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

Required Field

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

26. PAYEE INFORMATION

32. SERVICE FACTORS

DATE DUE

This is how the claim would look for 1 full month of billing if you provided services daily, billing Sunday through Saturday.



Billing for the week when services are provided every other day

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										22. MEDICAID RESUBMISSION CODE		ORIGINAL REF. NO.					
1. _____ 3. _____										23. PRIOR AUTHORIZATION NUMBER							
2. _____ 4. _____										11-digit PA number							
24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OF UNITS	H. ERSQT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	
From	To	MM	DD	YY	MM	DD	YY										
03	01	12	03	01	12	12			T1019					N5	10-digit API		
03	03	12	03	03	12	12			T1019					N5	10-digit API		
03	05	12	03	05	12	12			T1019					N5	10-digit API		
03	07	12	03	07	12	12			T1019					N5	10-digit API		
03	09	12	03	09	12	12			T1019					N5	10-digit API		
03	11	12	03	11	12	12			T1019					N5	10-digit API		
25. FEDERAL TAX I.D. NUMBER						SSN EIN		26. PATIENT'S ACCOUNT NUMBER								BALANCE DUE	
Required Field						<input type="checkbox"/> <input type="checkbox"/>											
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION							
Signature XXXXXX 6/11/2012																	

This is how the dates on the claim should look if services were provided every other day. You would NOT bill for the whole week, because services were not provided every day of the week



Billing end of month to new month in the middle of the week

	24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	PHYSICIAN OR SUPPLIER INFORMATION
	From MM DD YY	To MM DD YY	MM	DD	YY	YY										
1	03	01	12	03	07	12	12	T1019						N5	10-digit API	
2	03	08	12	03	14	12	12	T1019						N5	10-digit API	
3	03	15	12	03	21	12	12	T1019						N5	10-digit API	
4	03	22	12	03	28	12	12	T1019						N5	10-digit API	
5	03	29	12	03	31	12	12	T1019						N5	10-digit API	
6														N5	10-digit API	

If the month ends in the middle of the week, you must bill the start of the next month on a separate claim. For example, March ends on a Monday. Your first claim would be billed for dates of service 03/29/12, 03/30/12 and 03/31/12. On a separate claim, you will bill for the rest of the week beginning 04/01/12 through Saturday.

	24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	PHYSICIAN OR SUPPLIER INFORMATION
	From MM DD YY	To MM DD YY	MM	DD	YY	YY										
1	04	01	12	04	09	12	12	T1019	EP					N5	10-digit API	
2	04	05	12	04	11	12	12	T1019	EP					N5	10-digit API	
3	04	12	12	04	18	12	12	T1019	EP					N5	10-digit API	
4	04	19	12	04	25	12	12	T1019	EP					N5	10-digit API	
5	04	28	12	04	30	12	12	T1019	EP					N5	10-digit API	
6														N5	10-digit API	



Billing with multiple authorization dates

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)											22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.					
1. _____ 3. _____											23. PRIOR AUTHORIZATION NUMBER 12345678910					
2. _____ 4. _____																
24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER							
1	04	01	12	04	09	12	12	T1019	EP					N5	10-digit API	
2													NPI			
3													NPI			

If there are multiple Prior Authorizations, they must be billed on **separate** claim forms. They may NOT be combined.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)											22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.					
1. _____ 3. _____											23. PRIOR AUTHORIZATION NUMBER 23456789101					
2. _____ 4. _____																
24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER							
1	04	10	12	04	16	12	12	T1019	EP					N5	10-digit API	
2													NPI			
3													NPI			



Billing with multiple authorization dates

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)											22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.			
1. _____ 3. _____											23. PRIOR AUTHORIZATION NUMBER 12345678910			
2. _____ 4. _____														
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY		CPT/HCPCS	MODIFIER						
1	04	01	12	04	09	12	12	T1019	EP				N5	10-digit API
2													NPI	
3													NPI	

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1. _____ 3. _____											23. PRIOR AUTHORIZATION NUMBER 23456789101			
2. _____ 4. _____														
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY		CPT/HCPCS	MODIFIER						
1	04	10	12	04	16	12	12	T1019	EP				N5	10-digit API
2													NPI	
3													NPI	



Reference List

Reference	Location
Medicaid Services Manual Chapter 3500	http://dhcfp.nv.gov/MSM/CH3500/MSM%20Ch%203500%20FINAL%2011-08-11.pdf
Billing Information	http://www.medicaid.nv.gov/providers/BillingInfo.aspx



Questions and answers



THANK YOU FOR ATTENDING TODAY

Enjoy your day

